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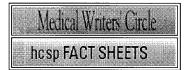


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### **HEPATITIS C CASE: Woman loses lawsuit, seeks better infection control in hospitals**

By <u>PAUL HARASIM</u> LAS VEGAS REVIEW-JOURNAL

Debra Fox, suffering from nausea that she says is a residual effect of the interferon treatment she underwent to fight off hepatitis C, whispered to her attorney that she would have to delay testifying again.

At any minute, the jurors who had been out on lunch break would be returning to listen to an afternoon of witnesses in the medical malpractice lawsuit that Fox filed after contracting the potentially deadly virus that attacks the liver.

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After all, lawsuits are plentiful in the wake of a Las Vegas hepatitis outbreak that saw public health authorities advise thousands of patients of Dr. Dipak Desai's endoscopy clinics to undergo testing in 2008 for hepatitis and HIV.

But consider this: Fox's lawsuit, filed by attorney Steve Day, wasn't against a Desai clinic but rather against Spring Valley Hospital, one of five Southern Nevada hospitals in the Valley Health System, a subsidiary of Universal Health Services Inc., one of the largest health care management companies in the nation.

Even though she lost her case against the hospital -- the jury returned a verdict about 75 minutes after receiving the case Thursday afternoon -- Fox hopes that her suit can help persuade people that they have to take control of their care.

"I'll still consider it a victory if my case makes people start asking more questions about what's being done regarding infection control," she said, weeping. "We can't let any more people be hurt because simple safety precautions aren't taken."

During the four-day trial, Fox, 48, unsuccessfully argued that she acquired acute hepatitis C during a five-day stay at Spring Valley for a November 2006 surgery. Within just a few weeks of the procedure to remove a large ovarian cyst, she developed the high fevers and complex gastric problems that tests determined were caused by the virus.

Mike Prangle, an attorney for the hospital, said late Thursday that he was gratified that the jury realized that the evidence did not show that Fox acquired the virus at Spring Valley.

"I believe they saw that the hospital had the proper safety protocols in place," he said. "Obviously, we have great sympathy for what Ms. Fox has gone through and wish her the best."

Fox's case illustrates how difficult it often is to determine how the virus is transmitted without the benefit of DNA testing genetically linking cases to procedures.

Though hundreds of people have said they were infected at Desai's clinics, for example, only seven cases were genetically linked.

That means most individuals who had procedures at Desai's clinics will have to convince juries, as Fox tried to do, that they did not have significant risk factors for acquiring the disease, including other surgeries, risky sex or needle sticks.

Day admitted in an interview Tuesday that Fox's case would be difficult to prove.

"Basically, what we're talking about is a matter of probability," he said. "We believe the probabilities were greater for her getting hepatitis C at Spring Valley during her five-day stay."

But on Nov. 4, 2006, 18 days before her surgery, Fox had blood drawn in the emergency room at Summerlin Hospital, another member of the Valley Health System. Theoretically, Day conceded, Fox could have been stuck with an infected needle during her trip to an emergency room for gastritis.

And on Nov. 13, 2006, nine days before her surgery, Fox had a colonoscopy at the Ambulatory Surgical Center of Southern Nevada. The facility is not associated with Desai and was given a clean bill of health by inspectors who, in the wake of the Desai clinics' outbreaks, surveyed all of the state's clinics in regard to infection control practices.

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Gish, who has patients in both Nevada and California, testified it was his expert opinion that Fox acquired hepatitis at the hospital, that there had to have been a break in standard disease practices and precautions.

But under cross-examination by hospital attorney Prangle, Gish admitted he couldn't pinpoint how Fox was infected at the hospital. He did not know, he said, whether it happened during surgery or during treatment at the hospital before or after her procedure.

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Harold Edwards, manager of Spring Valley's operating room, testified that proper sterilization techniques were used at the hospital when Fox had her surgery.

He noted that federal and state surveys of the hospital by public health officials found no deficiencies in infectious disease practices and precautions in the operating room in 2006.

Unfortunately, according to a government report issued earlier this month, the nation's hospitals aren't always protecting patients from potentially fatal infections.

The report issued by Health and Human Services found that as many as 98,000 people a year die from medical errors, and that preventable infections -- along with medication mix-ups -- are a significant part of the problem.

Though highly emotional after losing her case, Fox, who says she lost her information technology job because of the side effects of the treatment, continued to implore people to aggressively manage their care.

"The public should not get complacent about the transmission of this terrible disease at medical facilities," Fox said. "I want people to remember that it isn't just one health-care setting that we have to be concerned about."

Public health authorities support Fox's contention.

"Hospitals are not immune to this problem (the spread of blood-borne pathogens)," Joe Perz, an epidemiologist with the Centers for Disease Control and Prevention, said Wednesday.

A recently released government study found that in the past 11 years, 620 patients were infected in 52 outbreaks, with the CDC reporting that 10 outbreaks occurred at hospitals while 42 occurred in nonhospital settings that included clinics, ambulatory surgical centers, hemodialysis and long-term care centers. Thousands have had to undergo testing for the disease.

In February a former Denver hospital technician was sentenced to 30 years in prison for swapping drug-filled syringes intended for patients with used syringes whose needles were contaminated with the deadly hepatitis C virus.

DNA testing has found that the needle swapping in 2008 and 2009 infected at least 18 patients at Denver's Rose Medical Center.

Over that same time period in Florida, nearly 2,000 people were urged to get tested after Broward General Medical Center officials reported that a nurse used IV bags contaminated with other patients' fluids while administering saline solution to patients who came to the hospital for cardiac chemical stress tests. Testing continues to see if any new cases of the virus can be linked to the South Florida hospital.

There is a strong possibility, Perz said, that public attention brought to tragic cases like the one involving Fox will benefit the public.

"It creates more scrutiny of safety practices," he said. "What happened in Las Vegas (at the Desai clinic) has already led to safer injection practices around the country."

Contact reporter Paul Harasim at pharasim@review journal.com or 702-387-2908.

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Dr Jefferies said the procedures were done at Port Hedland Hospital between June 1, 2008 and April 1, this year and at Nickol Bay Hospital on March 10 this year.

The doctor was practising at Derby Hospital between April 5 and 9 this year.

Other practices by the anaesthetist were being examined and an audit of the doctor's patients who may have undergone other procedures at all three hospitals is underway, Dr Jefferies said.

A hotline - 1800 020 080 - has also been set up for patients who have concerns.

Back to top

April 30, 2010

**HEPATITIS C CASE: Woman Loses Lawsuit, Seeks Better Infection Control in Hospitals** 

http://www.lvrj.com by Paul Harasim Las Vegas Review-Journal

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#### Back to top

FDA Considers Expanded Use of HCV Drugs <a href="http://www.medpagetoday.com">http://www.medpagetoday.com</a>

By Emily P. Walker,

Washington Correspondent, MedPage Today

ROCKVILLE, Md. -- The FDA heard public testimony Friday on establishing a compassionate use program that would allow severely ill hepatitis C (HCV) patients access to investigational, direct-acting antiviral agents.

One of the current treatments for HCV -- pegylated interferon alfa-2a and ribavirin (Rebetol) -- is highly toxic with a response rate of about 50%, clinical data show. That number is much lower in real-world cases, according to a number of physicians who testified during the public hearing.

The FDA understands current treatment options are not good enough, an official said. "Current control of hepatitis C is not working," said Peter Lurie, MD, of the FDA's Office of the Commissioner.

Friday's meeting was called in response to a petition by groups seeking access to the drugs for individuals often excluded from clinical trials.

Clinical trials are only open to a small subset of real-world HCV patients, noted Diana Sylvestre, MD, who treats HCV-infected intravenous drug users in the San Francisco area. Yet, there are many HCV patients who cannot tolerate current treatments, she said.

Her patients are rarely accepted into clinical trials, she



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# Indictments in hepatitis case sought

Jeff German

By JEFF GERMAN

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Clark County **prosecutors** Thursday asked a grand jury to indict Dr. Dipak Desai, the central figure in the valley's hepatitis C scare in 2008, and two of his former clinic workers on criminal charges, a well-placed courthouse source told the Review-Journal.

Indictments are normally unsealed in District Court on Friday mornings.

Desai, who once enjoyed strong community and political connections, ran the endoscopy clinics where health officials said patients had been infected with the hepatitis C virus because of unsafe injection practices.

**Prosecutors** with the district attorney's major crime and fraud units — who spent much of the afternoon behind closed doors with the grand jury — were looking to charge Desai with several felonies, including patient neglect and insurance fraud, the source said.

At least seven patient neglect charges could be included in an **indictment** of Desai — one for each of the seven people health officials said were infected with hepatitis C at Desai's now-closed main clinic, the Endoscopy Center of Southern Nevada, 700 Shadow Lane, the source said.

**Prosecutors** previously have said they couldn't recall the district attorney's office ever filing a patient neglect charge against a physician.

The statute requires **prosecutors** to prove that Desai and his staff reused syringes and vials of the sedative propofol to save money knowing that they were endangering the lives of patients.

Las Vegas police investigated the case under the theory that the patients who were infected with the virus suffered substantial bodily harm. Each count of patient neglect that results in substantial bodily harm is punishable under the law by a maximum of six years in prison.

Desai's chief criminal lawyer, Richard Wright, said late Thursday that he had not heard about any grand jury activity in the case during the day, and he declined further comment.

The identities of the two clinic employees **prosecutors** have sought to indict with Desai could not be learned, but the courthouse source said the workers were anesthetists involved in administering the sedative propofol to patients during routine colonoscopies.

**Prosecutors** confirmed in March that they had begun presenting witnesses to the grand jury. They had planned to **seek** an **indictment** that month, but they ended up calling additional witnesses and ran into problems scheduling time with the grand jury.

At least a half-dozen former clinic patients infected with the hepatitis C virus were among those who have testified before the grand jury, the courthouse source said.

In November, when they brought the criminal case to the district attorney's office for prosecution, Las Vegas police recommended Desai and at least four other clinic workers be charged.

The criminal investigation, which began shortly after health officials disclosed the hepatitis C outbreak in February 2008, was one of the largest police said they had ever undertaken. A final report submitted by police to the district attorney's office was 100 pages with some 10,000 pages of supporting documents. In all, police said they interviewed some 100 witnesses, seized 100 computers and pored over 100,000 patient files.

Desai came under scrutiny after the Southern Nevada Health District linked cases of hepatitis C to the Endoscopy Center of Southern Nevada. Officials notified 40,000 former clinic patients about possible exposure to blood-borne diseases because of unsafe injection practices. More notifications followed to patients of a sister clinic, Desert Shadow Endoscopy Center.

Investigators blamed the outbreak on nurse anesthetists reusing single-dose medicine vials among patients.

Clinic staff told health investigators they were ordered by administrators, principally Desai, to reuse supplies and medications to save money, according to a city of Las Vegas letter suspending the Shadow Lane clinic's business license.

In the months following the hepatitis outbreak, Desai's lawyers have said he was in ill-health because of a series of strokes. He has given up his license to practice medicine and filed for bankruptcy. He also has become a defendant in dozens of medical malpractice lawsuits, involving several thousand former patients.

Last month, in the first trial stemming from the massive endoscopy litigation, a jury awarded Las Vegan Henry Chanin and his wife \$500 million in punitive damages after finding the drug companies who distributed propofol to Desai's clinics liable in his hepatitis C infection at the Desert Shadow clinic. Desai had reached an undisclosed settlement with the Chanins prior to the trial.

Contact Jeff German at jgerman@reviewjournal.com or 702-380-8135 or read more courts coverage at lylegalnews.com.

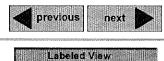


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